DEBORAH SENN
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

4394 02/14/00 $55,000.00

OLYMPIA OFFICE:
INSURANCE BUILDING
P.O. BOX 40255
OLYMPIA, WA 98504-0255
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OFFICE OF
INSURANCE COMMISSIONER

In the Matter of	)	
	)	
	)	
PREMERA BLUE CROSS,	)	No. D 2000-10
A Registered Health Care Service Contractor	)	Consent Order Levying A Fine
	)	
and	)	
	)	
PREMERA HEALTH PLUS	)	
A Registered Health Maintenance Organization	)	

FINDINGS OF FACT:

1. Premera Blue Cross is a health care service contractor registered to do business in Washington State. Premera HealthPlus is a health maintenance organization registered to do business in Washington State. (Premera Blue Cross and Premera HealthPlus are collectively referred to for purposes of this Order as "Premera" or the "Companies").

2. In April 1998, the Office of the Insurance Commissioner ("OIC" or the "Agency") met with the region's leading emergency room directors. They were concerned that insurance carriers were denying valid emergency room claims, thereby discouraging the public from seeking emergency care and posing a serious potential health risk to the public.

3. In May 1998, the OIC initiated a Target Market Conduct Examination of Premera to determine if the Companies were complying with the new emergency room law, RCW 48.43.093. The law went into effect January 1, 1998.

4. The examination focused on emergency room claims during the first four months of 1998. Premera Blue Cross processed 20,897 claims for emergency treatment during that period, of which 1,435 were initially denied. The OIC examined a sample of those denials using techniques approved by the National Association of Insurance Commissioners (NAIC).

5. On March 1, 1999, the OIC notified Premera that it had concerns about the Companies' handling of emergency room claims; the contents of the Companies' contracts and provider manuals relating to emergency room claims treatment; and the handling of third-party liability claims. During the balance of 1999 the OIC conducted an investigation of the Companies' practices which were the subject of the examination.

6. The examination and the investigation showed that it was Premera's practice to send subscribers a questionnaire ("Incident Questionnaire") in certain circumstances to determine whether coverage applies. For example, an Incident Questionnaire may be sent to determine if the claim in question is subject to an exclusion, or if a third party may be liable for the claim. If a subscriber provides an incomplete response to the Incident Questionnaire, the Companies send a follow-up form ("Follow-Up Questionnaire") to obtain the omitted information. In the event the subscriber fails to respond to the Incident Questionnaire, or fails to submit the information requested in the Follow-Up Questionnaire, the claim may be denied in an Explanation of Benefits form ("EOB"). In instances where they received no response to the Incident Questionnaire, the Companies denied the claim without conducting further follow-up prior to sending a denial in an EOB. The OIC believes that the Incident Questionnaire and Follow-Up Questionnaire used by the Companies did not clearly warn subscribers of the consequences of failing to respond in a full and timely manner. The OIC determined that the EOB does adequately notify subscribers that a claim cannot be processed until a completed Incident Questionnaire is returned and the EOB form requires no change.

7. The examination and investigation showed that it was Premera's practice to deny emergency room claims when they were part of a disputed in-patient hospital bill. The Companies failed to treat the emergency room portion of the claim separately from the portion related to the hospital admission, for which the Companies can require authorization. In such cases, subscribers were provided an EOB that indicated the subscriber had no responsibility for payment. The OIC believes that denial of the emergency room portion of the claim to the provider violated the emergency room law.

8. The OIC believes that provisions related to emergency room care in the Premera Blue Cross "Blue Choices Contract" and the Premera HealthPlus "Managed Care Operations Manual" indicated that the Companies had discretion to deny emergency room claims in violation of the emergency room law and therefore were misleading to subscribers and providers.

9. There is no evidence that the Companies had any intent to violate the emergency room law and the OIC believes the Companies intended to comply with the law.

10. The Companies cooperated fully with the OIC in the examination and investigation of their practices, and worked with the OIC to develop mutually agreeable changes to address the OIC's concerns.

11. The OIC found that the Companies' other emergency room claims practices during the period under investigation, January through April 1998, complied with applicable law.

CONCLUSIONS OF LAW:

The OIC, as a result of its examination and investigation, has reached the following conclusions:

1. Premera's handling of emergency room claims violated RCW 48.43.093 because the Incident and Follow-Up Questionnaires failed to warn consumers of the consequences of not responding in a full and timely manner.

2. Premera's denial of emergency room claims violated RCW 48.43.093 because it denied valid emergency room claims when they were part of a disputed in-patient hospital bill.

3. Premera's Blue Choices Contract and Managed Care Operations Manual violated RCW 48.43.093 because they indicated that the Companies had sole discretion to deny emergency room claims.

4. RCW 48.05.185 and RCW 48.44.166 authorize the Commissioner to impose a fine in lieu of the suspension or revocation of a company's certificate of authority.

CONSENT TO ORDER:

Premera hereby consents to the entry of this Order as a stipulated settlement to resolve differences with the OIC in an amicable manner without the costs and inconvenience of litigation. By agreement of the parties, the OIC has agreed to this stipulated settlement on the condition that:

1. Premera pay a fine of $55,000 within thirty days of the entry of this Order.

2. Premera revise the Incident Questionnaire form to include the changes set forth in Exhibit A.

3. Premera revise the Follow-Up Questionnaire form to include the changes set forth in Exhibit B.

4. Premera revise the Blue Choices Contract section relating to Medical Emergency Care to the text set forth in Exhibit C. Premera may make subsequent changes to this text only if such changes are consistent with RCW 48.43.093 and other applicable law. Nothing in this Order creates a separate obligation for Premera to obtain prior OIC approval for future changes to the text beyond the requirements of applicable law.

5. Premera revise the section of the Managed Care Operations Manual (currently known as the Practitioner Manual) relating to Medical Emergency to the text set forth in

Exhibit D. Premera may make subsequent changes to this text only if such changes are consistent with RCW 48.43.093 and other applicable law. Nothing in this Order creates a separate obligation for Premera to obtain prior OIC approval for future changes to the text beyond the requirements of applicable law.

6. Premera revise its practices for bundled emergency room and in-patient hospital claims as set forth in Exhibit E.

Premera agrees to implement Paragraphs 2-6 of this Consent to Order within sixty (60) days of the entry of this Order.

The $55,000 fine must be paid in full within thirty days of the entry of this Order. Pursuant to RCW 48.05.185, failure to pay the fine within the allotted time shall constitute grounds for revocation of Premera's certificate of authority, and for the recovery of the fine in a civil action brought on behalf of the Insurance Commissioner by the Attorney General of the State of Washington.

Premera acknowledges its duty to comply fully with the applicable laws of the State of Washington.

Premera acknowledges that the OIC has made the Findings of Fact and Conclusions of Law as set forth in this Order. Premera does not concur with the Conclusions of Law and certain of the Findings of Fact and has consented to this Order and acknowledged the OIC's Findings of Fact and Conclusions of Law subject to the following terms:

Nothing in this Order shall be construed as an agreement by the Companies with the OIC's conclusions that their prior practices violated applicable law, and

The Companies believe such practices, including their handling of emergency room claims and the prior versions of the documents which are the subject of this Order, fully complied with applicable law; and

The changes agreed to by the Companies as provided in this Order fully address the OIC's concerns about the Companies' practices which were reviewed in the examination and investigation, and

No further enforcement action will be initiated by the OIC with respect to the Companies' existing emergency room practices which were reviewed in the examination and investigation, subject to the Companies' compliance with the terms of this Consent Order; and

The parties have entered into this Order as a settlement to resolve their differences in an amicable manner without the costs and inconvenience of litigation.

EXECUTED this 28th day of January 2000.

PREMERA BLUE CROSS AND
PREMERA HEALTHPLUS

By _____

Yoram Milo
Chief Legal Officer, Premera Blue Cross

ORDER

Pursuant to RCW 48.05.185, the Insurance Commissioner hereby imposes a fine of one hundred and ten thousand dollars ($110,000) upon Premera, of which fifty five thousand ($55,000) is suspended. Premera must pay $55,000 within thirty days of the date of entry of this Order. Failure to pay this amount within the allotted time shall constitute grounds for revocation of Premera's certificate of authority, and for recovery of the fine in a civil action brought on behalf of the Insurance Commissioner by the Attorney General of the State of Washington.

The Commissioner may impose the balance of the suspended fine and initiate proceedings to suspend or revoke the Companies' certificates of authority should they fail to meet the other conditions set forth in Paragraphs 2-6 in the "Consent to Order" section of this Order.

The OIC hereby adopts this Consent Order, including the terms and conditions provided for and agreed to by Premera in the "Consent to Order," as a stipulated settlement to resolve the matters in dispute which are the subject of this Order.

ENTERED AT OLYMPIA, WASHINGTON, this 28th day of January 2000.

DEBORAH SENN
Insurance Commissioner

By _____

Jeffrey Coopersmith
Deputy Commissioner Legal Affairs

EXHIBIT A

Approved Changes to Incident Questionnaire

The notice paragraph of the Incident Questionnaire shall be modified to include the new language shown as underlined text as set forth below. The OIC agrees that no follow-up is required prior to issuance of a denial if a subscriber fails to return a completed Incident Questionnaire within the time prescribed.

> In order to proceed with the processing of your health care claims we need your help. Please return this form within FIVE DAYS with complete answers to all questions ON BOTH SIDES. THIS CLAIM CANNOT BE PROCESSED UNTIL THIS INCIDENT QUESTIONNAIRE IS FULLY COMPLETED, SIGNED AND RETURNED. NOT ANSWERING ANY QUESTION MAY CAUSE A DELAY IN BENEFIT DETERMINATION. FAILURE TO RETURN THE QUESTIONNAIRE WILL RESULT IN DENIAL OF THE CLAIM. Thank you for your prompt attention. We appreciate your assistance in providing this information so that we may complete the processing of your claim(s).

EXHIBIT B

Approved Changes to Follow-Up Questionnaire

Add notice provision to Follow-Up Questionnaire consistent with following text:

In order to proceed with the processing of your health care claims we need your help. Please return this form within **FIVE DAYS** with complete answers to all marked questions. **This claim cannot be processed until the requested information is returned. Failure to return this form or failure to respond to the marked question(s) will result in denial of the claim.** Thank you for your prompt attention. We appreciate your assistance in providing this information so that we may complete the processing of your claim(s).

EXHIBIT C

Approved Text for Medical Emergency Care Section of Blue Choices Contract

Medical Emergency Care

A "medical emergency condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, or if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy. (A "prudent layperson" is someone who has an average knowledge of health and medicine.)

Examples of medical emergencies are severe pain, suspected heart attacks, and fractures. Examples of non-emergencies are minor cuts and scrapes.

If you have a medical emergency, call 911 or seek care immediately. You may seek care in hospital emergency room, urgent care center or provider's office. Benefits for treatment of a medical emergency will be provided at your contract's highest benefit level.

For non-emergency situations, you can avoid unnecessary out-of-pocket costs by first contacting your PCP's office. Your PCP's office is available 24 hours a day, 7 days a week. If you reach an answering service, tell them you are a Blue Choices member, and briefly describe your problem. A PCP or other on-call practitioner is available 24 hours a day and will return your call with instructions on how to receive care.

If you are admitted to a hospital for a medical emergency, please contact our Member Services Department within 48 hours of admission, or as soon as medically possible.

You will receive the highest level of benefits for these non-emergency situations when your PCP coordinates your care. If you self-refer for non-emergency care, you will receive the lower level of contract benefits.

EXHIBIT D

Approved Text for Medical Emergency Section of Managed Care Operations Manual (Currently known as Practitioner Manual)

Medical Emergency

Medical Emergency means the emergent and acute onset of symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention; or that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the patient's health in serious jeopardy.

Most subscribers' contracts provide benefits for treatment in the Emergency Department only in case of a medical emergency.

Premera Blue Cross members are required to contact their PCP for care, except in the case of a Medical Emergency. PCP's must provide after-hours, and emergency care procedures and telephone numbers to their patients.

The Emergency Department is required to perform a medical screening examination for any individual seeking examination for treatment for a medical condition.

For presenting conditions that are not a medical emergency, the Emergency Department must call the PCP for authorization to treat past the point of screening and stabilization, unless the PCP called prior to member's arrival with such authorization. In such cases, the PCP is expected to respond within 30 minutes of being called or the member will be treated with assumed authorization to treat by the Emergency Department.

If a member is treated in the Emergency Department, any necessary follow-up care will need to be provided by the PCP (e.g., suture removal). Premera Blue Cross serves an important collaborative role with the PCP by educating members on the correct use of the Emergency Department. We will initiate member education based on a review of Emergency Department encounters and on request from the PCP and/or Emergency Department staff.

EXHIBIT E

Approved Procedures Relating to Bundled Emergency Room and In-Patient Hospital Claims

In cases where a provider submits claims to the Companies for emergency room services under a single bill with claims for non-emergency in-patient services (bundled claims), the emergency room component shall not be denied if it otherwise meets the requirements for coverage under RCW 48.43.093. Where the in-patient services in a bundled claim require authorization for the in-patient admission, the entire bundled claim may be pended subject to the following procedures:

- If the provider does not submit documentation to obtain authorization for the in-patient services, with or prior to submission of the claim, the entire bundled claim may be pended;

- The Companies shall request that the provider submit documentation for medical necessity review so that an authorization determination can be made for the in-patient services; the request shall indicate that the provider may identify charges associated with emergency room services in order to facilitate payment in the event that in-patient services are not approved;

- If, after submission of the appropriate documentation by the provider, the in-patient services are found to be covered under the subscriber contract, the allowable charges for the in-patient and emergency room components of the bill are to be paid.

- If the provider does not submit the requested documentation within 20 calendar days from the date of the company's request OR after the provider submits the requested documentation and the in-patient services are found not to be covered under the subscriber contract, the following shall apply: The Companies shall pay the allowable charges of the original bill that are clearly identified as emergency room services and may deny the remaining portions of the bill. The denial notice shall also notify the provider that if other portions of the denied bill were for unpaid emergency room services, the provider may submit a separate billing for such emergency room services. A statement as follows meets this requirement: "Submit unpaid ER charges."

DEBORAH SENN
STATE INSURANCE COMMISSIONER

STATE OF WASHINGTON

OLYMPIA OFFICE:
INSURANCE BUILDING
P.O. BOX 40255
OLYMPIA, WA 98504-0255
Phone: (360) 753-7300

OFFICE OF
INSURANCE COMMISSIONER

Letter of Understanding

Relating to Emergency Room Claims Dispute

1. In May 1998 the OIC initiated a Target Market Conduct Examination of emergency room claims processed by Premera Blue Cross and Premera HealthPlus (the "Companies") during the first four months of 1998. As part of the examination, the OIC reviewed various emergency room claims that involved coordination of benefits (COB).

2. Simultaneously with this letter, the OIC and Premera have entered into a Consent Order, No. D 2000-10, (the "Order") regarding the emergency room claim examination, and the Order does not address COB issues.

3. The OIC agrees that no fines or other sanctions will be applied with respect to the Companies' handling of COB in the period prior to and through the date of the entry of the Order.

4. It is the Companies' practice, when they have information that they are the secondary carrier, to deny claims if they are unable to coordinate benefits with the primary carrier. The OIC has concerns about this practice. The Companies believe this COB practice complies with applicable law.

5. The OIC agrees that the procedures in Exhibit A (attached hereto) meet applicable legal requirements when the Companies believe they are the secondary carrier.

6. The OIC shall not impose any fines or other sanctions or initiate any enforcement proceedings with respect to the Companies' current COB practices as secondary carrier provided that the Companies implement the procedures set forth in Exhibit A within 90 days of the date of this agreement.

7. Nothing in this agreement waives the Companies' rights to contest the OIC's interpretation of COB laws or to contest any enforcement action by the OIC with respect to such laws.

DATED this 28th day of January, 2000.

DEBORAH SENN
Insurance Commissioner

Premera Blue Cross

And

Premera HealthPlus

By _____
Jeffrey Coopersmith
Deputy Commissioner Legal Affairs

By _____
Yoram Milo
Chief Legal Officer, Premera Blue Cross

EXHIBIT A

COB PROCEDURE AS SECONDARY CARRIER

1. The Companies shall make a reasonable attempt to coordinate benefits with the primary carrier. If the Companies receive claim payment information from the primary carrier, the Companies will pay as secondary carrier.

2. The Companies may proceed as secondary carrier if, within the preceding 12 month period: (a) they have received other insurance coverage information from the subscriber or provider indicating that the Companies are secondary, or (b) another carrier has confirmed it is primary.

3. If the Companies are unable to coordinate benefits with the primary carrier (e.g., primary carrier fails to respond in a timely manner, does not provide its primary carrier payment information or indicates it has not received the claim), then the Companies shall attempt to contact the subscriber or provider by phone or in writing within 30 days of receipt of the claim to (a) confirm whether the subscriber continues to have coverage with the other carrier, and (b) request the other carrier's EOB payment information, if any.

4. If the Companies receive the information requested from the subscriber or provider, the following shall apply:

    - If primary coverage by another carrier is no longer in place, the Companies shall pay claim as primary carrier;
    - If primary coverage by another carrier remains in place and the primary carrier payment information is provided by the subscriber or provider, the Companies shall pay the claim as secondary carrier.

5. If the Companies do not receive the primary carrier's payment information:

    - The Companies shall, no later than the 60th calendar day after receipt of the claim, estimate the amount to be paid as secondary carrier and pay such amount. The estimate of payment is to be based, at the Companies' election, on either (a) the Companies' prior claims experience with that subscriber or (b) other reasonable benefit amount as determined by the Companies. In all circumstances, the estimate shall be deemed reasonable if it is based on the assumption that the primary carrier's benefit structure and payment allowance is identical to that of the Companies under the applicable subscriber contract for which the claim was submitted.

- The Companies shall send an Explanation of Benefits (EOB) to the subscriber and the provider notifying them that (a) payment was based on an estimate of payment to be made by the primary carrier, and (b) adjustments will be made if the Companies are provided a primary carrier EOB for the subject claim.

6. For purposes of the time requirements for payment under WAC 284-43-321, claims subject to this procedure shall be deemed unclean claims.

7. The Companies will provide the OIC copies of their written protocols, if any, once the procedures are implemented.

D2000-10

Premera Blue Cross
An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 327
Seattle, Washington 98111-0327

Remittance Schedule

Date		
02	02	2000

OFFICE OF THE INS. COMMISSIONER
PO BOX 40257 INSURANCE BLDG.
OLYMPIA WA 98504-0257

100890
Vendor #

50392985
Check #

Invoice Date	Invoice Num	Voucher Num	Bank Code	GL Num	Cost Center	LOB	Corp Code	Invoice Description	Distribution Amount
000131	013100	164572	BC	62470	S009	2100	BCW	CONSENT ORDER NO D 2000-10	55,000.00
								CHECK TOTAL	55,000.00

REPLACES 600-4509 600-REMBCR (DPIWFDL)